



**MARYLAND**  
Department of Health

**Maryland Electronic Health Records (EHR)  
Incentive Program  
Registration and Attestation System**

**Provider User Guide**

**Version 5**

**2017**

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## Introduction

To facilitate enrollment in the Maryland Medicaid EHR Incentive Program, Maryland utilizes the electronic Medicaid Incentive Program Payment (eMIPP) system. This document outlines the necessary requirements for providers and hospitals to attest in eMIPP.

If you are a hospital representative seeking to attest with Maryland, please signal your intent to participate by emailing [mdh.MarylandEHR@maryland.gov](mailto:mdh.MarylandEHR@maryland.gov). Although general information about accessing, registering, and attesting in eMIPP is provided in this document, additional instructions for hospital participation will be provided on an individual basis.

Hospitals will not be paid by Maryland until they have signaled their intent to register and attest by emailing the State at [mdh.MarylandEHR@maryland.gov](mailto:mdh.MarylandEHR@maryland.gov).

All other providers please follow the instructions listed below.

## Getting Started

To qualify to register with the Maryland Medicaid Electronic Health Record (EHR) Registration and Attestation System, providers must complete these two steps:

### Step 1: Verify Eligibility and Register with CMS

- a. Verify eligibility to participate in the Medicaid EHR Incentive Program – read the information available on our [homepage](#).
- b. Register with the Centers for Medicare and Medicaid Services (CMS) – go to <https://ehrincentives.cms.gov/hitech/login.action>.

Note: At the completion of CMS-level registration, providers will receive a confirmation number. This number may be referred to as either the CMS Registration Number or NLR Registration ID. Save this number; you will need it to complete State registration.

### Step 2: Verify Enrollment in Maryland Medicaid Fee-for-Service and eMedicaid

- a. To participate in the Maryland Medicaid EHR Incentive Program, all providers must be enrolled with Maryland Medicaid Fee-for-Service. Although all providers must be enrolled in Maryland Medicaid Fee-for-Service, they do not need to participate in the Fee-for-Service program. If you do not know if you are registered as a Maryland Medicaid Fee-for-Service provider, or if you would like to register, contact Provider Enrollment at (410) 767-5340.
- b. Maryland also requires that providers enroll in eMedicaid, Maryland Medicaid's provider Web service portal. You can verify or create an eMedicaid account by going to <https://encrypt.emdhealthchoice.org/emedicaid/>. If you have any problems enrolling in eMedicaid, contact Provider Enrollment at (410) 767-5340.

Once a provider has completed these two steps, they may then proceed to the State Registration and Attestation System, <https://emipp.health.maryland.gov/>

## Browser Requirement

eMIPP is designed to be accessed through all major browsers including Chrome, Internet Explorer 11 (IE11), and Firefox. The site is best viewed in Google Chrome.

## Register for EHR Incentive Program

### Log In

Providers will receive their Registration ID (NLR Registration ID) after CMS registration (Step 1b above). You cannot sign in to the Maryland Medicaid Registration site without this number. To log into the Maryland EHR Registration and Attestation System, visit <https://emipp.health.maryland.gov/>.

If your eMedicaid username and password combination do not match with the CMS Registration ID, please check to make sure you have entered the correct ID. If the problem persists, it is likely that your eMedicaid profile is not associated with the individual National Provider Identifier (NPI) with which you enrolled with CMS for participation in the EHR Incentive Program.

Problems with your eMedicaid account can be addressed by calling Provider Relations at (410) 767-5503.

### Provider Registration

1. Login with eMedicaid username and password and click submit.
2. On the next screen, select Go.
3. Under eMIPP Registration, select Start.
4. Enter your 10-digit CMS Registration ID; select Search.
5. On the next screen, you will see a page with three tabs. By default, you will begin on Tab 1.

**Figure 1: Eligible Provider Registration ID**

Home Register Track Logout

**Find Registration**  
Enter your CMS Registration ID to begin your EHR Medicaid Incentive Payment Program (EHR MIPP) registration process.

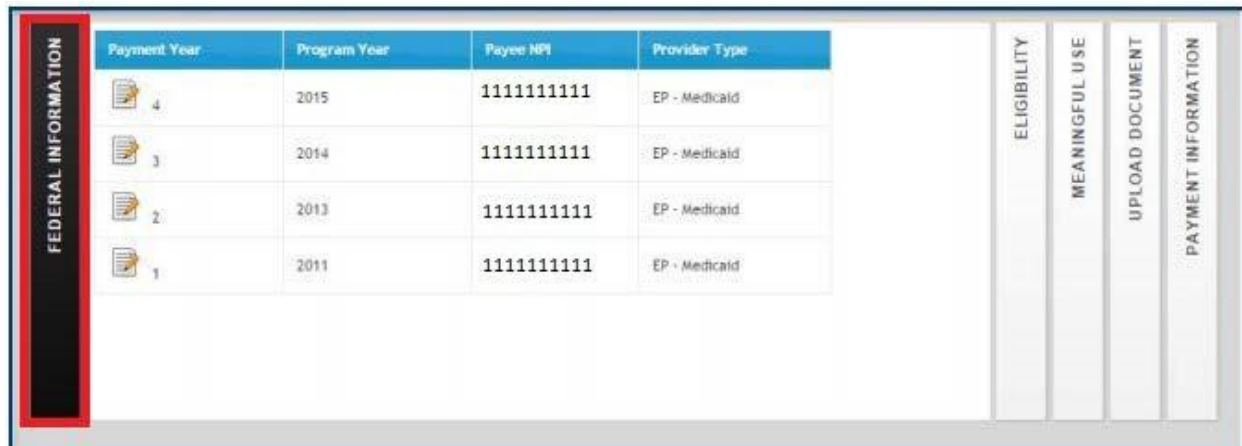
Enter CMS Registration ID:

Search

## Federal Information

On this tab, you need to review and confirm this information. The information is available by clicking on the icon that corresponds with your year of participation in the EHR Incentive Program. If this is your first year participating in the EHR Incentive Program, you will only see one icon.

**Figure 2: Eligible Provider Accessing Federal Information Screen**



The screenshot shows a web interface with a sidebar on the left labeled "FEDERAL INFORMATION" in a red box. The main area contains a table with four columns: "Payment Year", "Program Year", "Payee NPI", and "Provider Type". There are four rows of data, each with a document icon to the left of the "Payment Year" column. To the right of the table are four vertical tabs labeled "ELIGIBILITY", "MEANINGFUL USE", "UPLOAD DOCUMENT", and "PAYMENT INFORMATION".

Payment Year	Program Year	Payee NPI	Provider Type
4	2015	1111111111	EP - Medicaid
3	2014	1111111111	EP - Medicaid
2	2013	1111111111	EP - Medicaid
1	2011	1111111111	EP - Medicaid

The information on this slide is the exact information you entered with CMS. If there are any issues with the information that need to be corrected, STOP and go back to CMS and correct the issue(s). Then wait approximately 24 hours before accessing eMIPP. If the updated information is displayed, you can continue. If not, wait one more day and try again. If the new information is not displayed, call the CMS EHR Incentive Program Information Center. The hours are as follows:

7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.

1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

**Figure 3: Eligible Provider Federal Information**

The screenshot shows a window titled "Federal Information" with a close button in the top right corner. The window is divided into four main sections: "Personal Info", "Address", "Identifiers", and "Exclusions".

**Personal Info**

First Name : John  
Middle Initial : Mid  
Last Name : Doe  
Suffix :  
Provider Type : Physician  
Provider Specialty : PEDIATRIC MEDICINE

**Address**

Address : 1 Address  
City : My City  
State : MD  
Zip : 21111  
Phone : (301) 111-4444  
Ext : 21  
E-mail : myemail@email.com

**Identifiers**

The Tax Identification Number (TIN) captured below will receive the EHR incentive payment.

Payee NPI : 1111111111  
Payee Tax ID : 999999999

**Exclusions**

Code	Description	Date
No Exclusions Found.		

Close

**NOTE:** Maryland will use the e-mail address listed in Figure 3 as the primary means of contact with you. Please make sure this is a valid e-mail address and that the inbox it is associated with is frequently monitored. After reviewing the information on Tab 1, click on Tab 2, ELIGIBILITY.

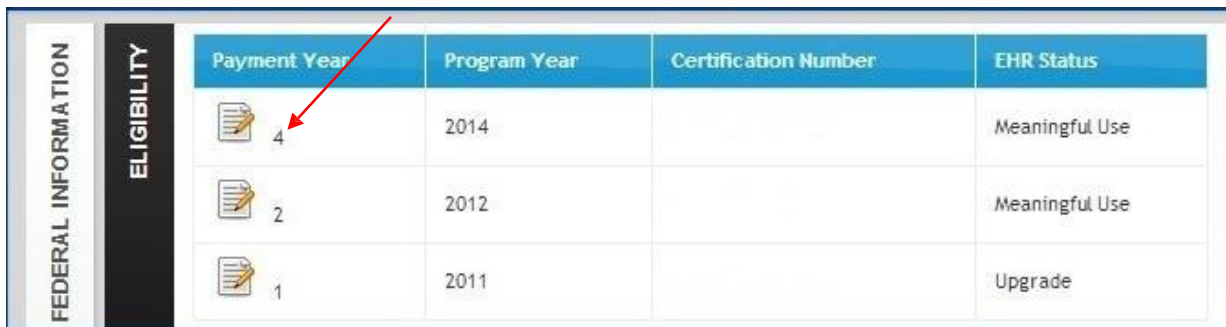


## Submit Eligibility Information

All providers must attest to meeting eligibility criteria for participation in Medicaid EHR Incentive Program. This must be completed every year of participation.

1. In Tab 2: Eligibility, click on the Payment Year Icon for the most-recent program year to add your EHR eligibility details.

**Figure 4: Eligible Provider Accessing Eligibility Information Screen**



Payment Year	Program Year	Certification Number	EHR Status
4	2014		Meaningful Use
2	2012		Meaningful Use
1	2011		Upgrade

2. Enter Eligibility Information.

Refer to the six scenarios on pages 13 - 18 for more information on filling out this section; or, refer to Maryland Medicaid's State Registration video tutorial

[http://mmcp.health.maryland.gov/ehr/Videos/EP%20User%20Guide\\_01.2012.avi](http://mmcp.health.maryland.gov/ehr/Videos/EP%20User%20Guide_01.2012.avi)

**Figure 5: Eligible Provider Entering Eligibility Information**

**View Eligibility Information**

**Patient Volume Reporting Period**

Start Date:  ?

End Date:  ?

**Pay To Provider**

Select Pay To Provider ?

**Eligible Patient Volume**

Practice as a Pediatrician ? ☐ Yes ☒ No

Practice as a Physician Assistant ? ☐ Yes ☒ No

Hospital Based Provider ? ☐ Yes ☒ No

Include Organization Encounters ? ☐ Yes ☒ No

Render care in FQHC/RHC ? ☐ Yes ☒ No

Include MCO Encounters ? ☐ Yes ☒ No

Total Encounters:  ?

Medicaid Encounters:  ?

Did you include no-cost encounters? ? ☐ Yes ☒ No

Include encounters outside MD ? ☐ Yes ☒ No

**EHR Certification Information**

EHR Status ? ☒ MJ

EHR Certification Number:  ?

Email:

**Note:** Throughout this screen, any of the “?” icons can provide a pop-up tip for that item. Place your mouse over the icon and a pop-up tip will display.

**Patient Volume Reporting Period:** Enter the start date (in MM/DD/YYYY format) that you want to start your eligibility reporting period. This is not your meaningful use reporting period; it is the consecutive 90-day period in the prior calendar year that you are reporting your eligible/Medicaid patient volume. Once you fill in the start date, click in the end date field and the system will automatically fill in the end date. Both the start and end date must be in the prior calendar year—it cannot span multiple years. Your reporting period can be any consecutive 90-day period within the prior calendar year.

**Select Pay To Provider:** Providers may assign their incentive payment to themselves or reassign it to a Tax Identification Number (TIN) associated with an employer or entity with which they are affiliated with in the Medicaid Management and Information System (MMIS). All provider and employer relationships established in MMIS during Medicaid provider enrollment are valid pay-to entities that an attesting provider may select in eMIPP. If you do not see the entity you want to reassign the payment to in the drop down list, please contact Provider Enrollment at (410) 767-5340 to find out the group affiliation status with your desired pay-to entity.

**Eligible Patient Volume:** All providers must also complete this section; however, depending on how you answer the questions you will be prompted for slightly different information.

If yes, check all the boxes that apply. You must check at least one of the first three to be considered eligible.

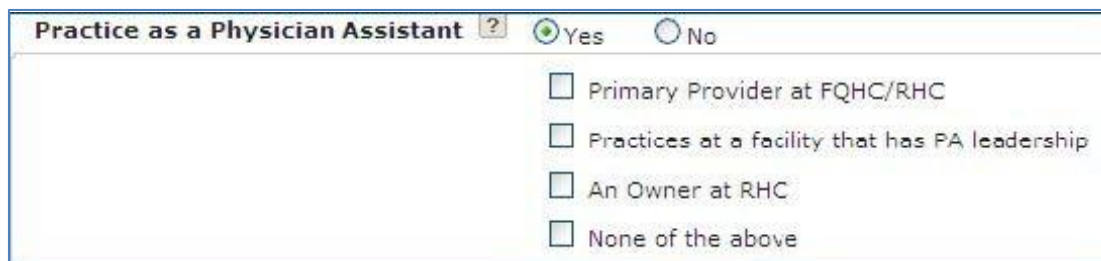
**Practice as a Pediatrician:** Only select this option if you are a Pediatrician.

**Practice as a Physician Assistant:** Only select this option if you are a Physician Assistant (PA) who practices predominantly in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is “PA-led.” In Maryland, “so led” has the following meanings:

1. When a PA is the primary provider in a clinic (for example, when there is a part-time physician or full-time PA); or
2. When a PA is a clinical or medical director at a clinical site of practice.

If you think you are a PA that meets one of these requirements, you must contact the Maryland Department of Health (MDH) at [mdh.MarylandEHR@maryland.gov](mailto:mdh.MarylandEHR@maryland.gov) before continuing with registration.

**Figure 6: Eligibility Information for Physician Assistant**



Practice as a Physician Assistant ? ☒ Yes ☐ No

☐ Primary Provider at FQHC/RHC

☐ Practices at a facility that has PA leadership

☐ An Owner at RHC

☐ None of the above

**Hospital Based Provider:** Only select this box if you rendered any care in a hospital setting during the reporting period. A provider is considered hospital-based if at least 90% of their paid Medicaid encounters from the previous calendar year (prior to the Program Year) were performed in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The percentage determination is made based on the total number of Medicaid encounters during the provider's reporting period.

When you select “yes,” an additional question will appear asking for the numbers of encounters in the hospital setting. In order to be eligible to participate in the Medicaid EHR Incentive Program, you must have less than 90 percent of your covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The only exception is for providers practicing predominantly in an FQHC or RHC.

**Figure 7: Eligibility Information for Hospital-Based Provider Determination**

<b>Hospital Based Provider</b> ?		<input checked="" type="radio"/> Yes	<input type="radio"/> No
<b>Total Inpatient Discharges:</b>	<input type="text"/>	?	
<b>Medicaid Inpatient Discharges:</b>	<input type="text"/>	?	
<b>Medicaid ER Encounters:</b>	<input type="text"/>	?	
<b>Total ER Encounters:</b>	<input type="text"/>	?	

Depending on how you answer Include Organization Encounter, Render Care in FQHC/RHC, and Include Managed Care Encounters, you will be asked for different encounter volume items. Each of the scenarios is explained below. Refer to the [video tutorial](#) for additional scenarios.

**Scenario 1:**

Include Organization Encounters = No

Render Care in FQHC/RHC = No

Include MCO Encounters = No

**Figure 8: eMIPP Default Eligibility Scenario**

Eligible Patient Volume		
Practice as a Pediatrician	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Practice as a Physician Assistant	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Hospital Based Provider	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Include Organization Encounters	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Render care in FQHC/RHC	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Include MCO Encounters	<input type="radio"/> Yes	<input checked="" type="radio"/> No
<div>Total Encounters: <input type="text"/> ?</div> <div>Medicaid Encounters: <input type="text"/> ?</div>		
Did you include no-cost encounters?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Include encounters outside MD	<input type="radio"/> Yes	<input checked="" type="radio"/> No

This is the simplest scenario. Enter your total encounters (all payers, all locations) and your Medicaid encounters in the provided fields.

## Scenario 2:

Include Organization Encounter = Yes

Render Care in FQHC/RHC = No

Include MCO Encounters = N/A

**Figure 9: Selection Criteria for Choosing “Group Proxy”**

The screenshot shows a web form titled "Group Proxy" with the following fields and options:

- Include Organization Encounters**: Radio buttons for "Yes" (selected) and "No".
- Organization NPI**: A text input field with a question mark icon.
- Render care in FQHC/RHC**: Radio buttons for "Yes" and "No" (selected).
- Total Encounters**: A text input field with a question mark icon.
- Medicaid Encounters**: A text input field with a question mark icon.

Under this scenario, you are electing to use your Practice/Organization’s encounter numbers as a proxy. This is optional. You will need to provide the group or organization NPI that you are using as a proxy and Practice/Organization’s encounter numbers. If you are choosing to use the “group proxy” approach to determine patient volume, you need to pool all the encounters for the entire group, including those who are not eligible provider types for participation in the EHR Incentive Program. Further, if you choose the “group proxy,” no individual group member can apply for an EHR Incentive using their individual patient volume. Either the whole group participates using the group proxy or no one does.

To ensure that Medicaid has collected all group members before reviewing your attestation, you should upload your group roster for the patient volume period (see page 7). If you do not upload your roster, Medicaid will contact you via the email address available under the "Federal Information" tab (see page 7).

In some cases, Maryland Medicaid may instruct you to enter your group NPI, even if you are not choosing to use the “group proxy” approach. This is to ensure that Medicaid collects all available Medicaid encounters for a particular provider under the group.

**Note:** “Include MCO Encounter” is not a viable option in this scenario; however, you can still calculate your patient volume with your Managed Care Organization (MCO) encounters. You should include MCO encounters when calculating total and Medicaid encounters. For a list of MCOs, please refer to the [HealthChoice webpage](#).

### Scenario 3:

Include Organization Encounter = No

Render Care in FQHC/RHC = No

Include MCO Encounters = Yes

**Figure 10: Selection Criteria for Choosing to Include Managed Care Organization (MCO) Encounters**

**Include Organization Encounters** ? ☐ Yes ☒ No

**Render care in FQHC/RHC** ? ☐ Yes ☒ No

**Include MCO Encounters** ? ☒ Yes ☐ No

**Managed Care Encounters**

**Total Managed Care Encounters:**  ?

**Total Unduplicated Encounters:**  ?

**Total Medicaid Managed Care Encounters:**  ?

**Total Unduplicated Medicaid Fee-For-Service Encounters:**  ?

Under this scenario, you are electing to include your managed care encounters. You must provide managed care encounters for both Medicaid and total (all payers including Medicaid).

**Total Managed Care Encounters (1):** These are all your managed care encounters, including private and Medicaid. You may not have any private managed care encounters.

**Total Unduplicated Encounters (2):** All non-managed care based encounters. This includes Fee-For-Service Medicaid, private insurance, etc.

**Total Medicaid Managed Care Encounters (3):** All Maryland Medicaid MCO encounters.

**Total Unduplicated Medicaid Fee-For-Service Encounters (4):** All Maryland Medicaid Fee-For-Service encounters.

To get your percentage you do the following:

$(3+4) / (1+2) =$  percent of total encounters that are Medicaid.

#### Scenario 4:

Include Organization Encounter = No

Render Care in FQHC/RHC = Yes

Include MCO Encounters = No

**Figure 11: Selection Criteria for Choosing Rendering Care in an FQHC**

**Include Organization Encounters** ? ☐ Yes ☒ No

**Render care in FQHC/RHC** ? ☒ Yes ☐ No

**Include MCO Encounters** ? ☐ Yes ☒ No

**FQHC/RHC Encounters**

**Total Encounters:**  ?

**Medicaid Encounters:**  ?

**CHIP Encounters:**  ?

**Charity Care Encounters:**  ?

**Sliding Fee Scale Encounters:**  ?

**All Other Settings Encounters**

**Total Encounters:**  ?

**Medicaid Encounters:**  ?

Providers who practice predominantly in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) are allowed to include some additional types of encounters in their eligible patient volume. In this scenario, providers must supply encounter numbers both in the FQHC or RHC and outside the FQHC or RHC (in the “All Other Settings Encounters” section). If a provider only practices in an FQHC or RHC, these “All Other Settings Encounters” can be entered as zeros.

An EP “practices predominantly” at an FQHC or an RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months occurs at an FQHC or RHC. Providers can only use these additional types of encounters, i.e. charity care and sliding fee scale encounters, if they meet this requirement.



### Scenario 5:

Include Organization Encounter = Yes

Render Care in FQHC/RHC = Yes

Include MCO Encounters = N/A

**Figure 12: Selection Criteria for Choosing Rendering Care in an FQHC and Participating Using “Group Proxy”**

The screenshot shows a web form titled "Group Proxy" with the following sections:

- Include Organization Encounters**: A section with a question mark icon and two radio buttons, "Yes" (selected) and "No".
- Organization NPI**: A section with a question mark icon and a text input field labeled "Organization NPI:" followed by a question mark icon.
- Render care in FQHC/RHC**: A section with a question mark icon and two radio buttons, "Yes" (selected) and "No".
- FQHC/RHC Encounters**: A section with a question mark icon and five text input fields, each with a question mark icon:
  - Total Encounters:
  - Medicaid Encounters:
  - CHIP Encounters:
  - Charity Care Encounters:
  - Sliding Fee Scale Encounters:

Under this scenario, you are electing to use your Practice/Organization’s encounter numbers as a proxy. You will need to provide the group or organization NPI that you are using as a proxy and Practice/Organization’s encounter numbers.

To ensure that Medicaid has collected all group members before reviewing your attestation, you should upload your group roster for the patient volume period (see page 7). If you do not upload your roster, Medicaid will contact you via the email address available under the "Federal Information" tab (see page 7).

**Note:** You should include MCO Encounters when calculating total and Medicaid encounters. If you select this option you are also attesting to meeting the practices predominantly requirement in order to use a FQHC or RHC’s organization’s volume as a proxy. Also, please review the criteria described in Scenarios 2 and 4.

### Scenario 6:

Include Organization Encounter = No

Render Care in FQHC/RHC = Yes

Include MCO Encounters = Yes

**Figure 13: Selection Criteria for Choosing Rendering Care in an FQHC, Participating Using “Group Proxy,” and Including MCO Encounters**

Include Organization Encounters ☐ ? ☐ Yes ☒ No

Render care in FQHC/RHC ☐ ? ☒ Yes ☐ No

Include MCO Encounters ☐ ? ☒ Yes ☐ No

FQHC/RHC Encounters

Total Encounters:  ?

Non-Panel Medicaid Encounters:  ?

CHIP Encounters:  ?

Charity Care Encounters:  ?

Sliding Fee Scale Encounters:  ?

All Other Settings Encounters

Total Encounters:  ?

Medicaid Encounters:  ?

Managed Care Encounters

Total Managed Care Encounters:  ?

Eligible Patient Panel:  ?

In this scenario, you are selecting that you are practicing in an FQHC or RHC, have additional encounters in another setting, and also see Medicaid Managed Care patients.

**Note:** Please review the criteria described in Scenario 4.

All providers also have the option of including encounters from other states. If you select this option, you will be asked what other states were included. The inclusion of out-of-state encounters is optional and will initiate an eligibility verification audit. Medicaid staff will contact you for additional information and may contact the other state(s) to confirm encounter data; this will likely delay payment.

**Figure 14: Selecting Adopt, Implement, and Upgrade (AIU)**

**Include encounters outside MD** ? ☒ Yes ☐ No

**State(s):**  ?

**EHR Certification Information**

**EHR Status** ? ☐ Adopt ☐ Implement ☐ Upgrade

**EHR Certification Number:**

**Email:**

Enter the CMS EHR Certification ID for the EHR technology you are adopting, implementing, upgrading or currently using. This is not the ONC Certification Number. You should only enter one “EHR Certification Number.” The CMS EHR Certification ID is made up of 15 alphanumeric, case sensitive characters and should be entered in ALL UPPER CASE. The provider must also select their EHR status. For Year 1, providers must select and attest to adopting, implementing or upgrading to certified EHR technology. Select the most appropriate option.

This is also the section that includes an email address. If you provided one to the CMS Registration and Attestation System, it will be listed here. If you did not supply an email address to CMS, you must enter one in the space provided. The email address should be of the person completing the registration and who would like to be notified of its status.

## About the EHR Certification Number

During attestation, CMS requires each eligible professional to provide a CMS EHR Certification ID that identifies the certified EHR technology being used to demonstrate Meaningful Use. This unique CMS EHR Certification ID or Number can be obtained by entering the certified EHR technology product information at the Certified Health IT Product List (CHPL) on the ONC website

<https://chpl.healthit.gov/#/search>

**Note:** The ONC CHPL Product Number issued to your vendor for each certified technology is different than the CMS EHR Certification ID. Only a CMS EHR Certification ID obtained through CHPL will be accepted at attestation.


1. Eligible professionals can obtain a CMS EHR Certification ID by following these steps:
2. Go to the ONC CHPL website: <https://chpl.healthit.gov/#/search>
3. In the search box, you can choose to search by Product Name, Vendor Name, or CHPL Product Number.
4. Filter the search results according to the following filtering criteria: Certification Edition, Practice Type, Classification, Certified Criteria, and Certified CQMs.
5. Click on the check box next to the product desired to finalize the selection.
6. Select 'See Progress' to view the Progress page and view current status in relation to meeting necessary requirements to obtain a CMS EHR Certification ID.
7. Click on the 'Get Certification ID' button and the CHPL will generate and display a CMS EHR Certification ID which is representative of the combination of products selected.

Note: The "Get CMS EHR Certification ID" button will NOT be activated until the products selected meet 100% of the CMS required criteria. If the EHR products do not meet 100% of the CMS required criteria to demonstrate Meaningful Use, a CMS EHR Certification ID will not be issued. You may use this link to access a walk through document to generate a CMS EHR Certification ID using the CHPL website.

[https://www.healthit.gov/sites/default/files/policy/chpl\\_public\\_user\\_guide.pdf](https://www.healthit.gov/sites/default/files/policy/chpl_public_user_guide.pdf)

## Meaningful Use, Modified Stage 2 – Eligible Provider




The slide “Meaningful Use” shows a summary of your Meaningful Use information with the State.

The  icon shows the year of participation with the EHR Incentive Programs followed by the start and end date for your Meaningful Use period. Your Meaningful Use period is any continuous 90-day period in the calendar year.


This slide also shows the status of your Meaningful Use measures. If you have entered a valid value or selected exclusion for the number of Core/MU, Menu/PH, and Clinical Quality Measures (CQM) required under Meaningful Use for your year of participation, you will see the word “Complete” under the appropriate heading. If not, you will see the word “Incomplete.”

Click on the  icon to enter Meaningful Use information.

**Figure 15: Eligible Provider Meaningful Use Attestation Icon**

FEDERAL INFORMATION	ELIGIBILITY	MEANINGFUL USE	Year	Program Year	Start Date	End Date	Core/MU	Menu/PH	CQM
			 4	2015	01/01/2015	03/31/2015	Complete	Complete	Complete
			 3	2014	04/01/2014	06/29/2014	Complete	Complete	Complete
			 2	2013	07/31/2013	10/29/2013	Complete	Complete	Complete

## Meaningful Use Overview

When you click on the icon, you will be shown a page containing: (1) information about choosing your Meaningful Use period; (2) information about choosing your Meaningful Use CQM period; and (3) a system-generated check list showing your Meaningful Use status. Throughout the Meaningful Use web tool, you will see yellow notes providing helpful information. 

**Figure 16: Eligible Provider Meaningful Use Overview Screen**

**MU-Overview** Summary MU-Objectives MU-Public Health MU-Clinical Quality Measures Set

— Meaningful Use Reporting Period —

Start Date: 01/01/2015  
End Date: 03/31/2015

**Reporting Period**  
Enter reporting period Start Date and the End Date will automatically populate. This is a 90 day period in the current program year (2015).

— Meaningful Use CQM Reporting Period —

Start Date: 01/01/2015  
End Date: 04/15/2015

**CQM Reporting Period**  
This is a 90 day or greater period in the current program year 2015 and CQM reporting can be different than the reporting period for Meaningful Use.

— Meaningful Use Reporting Completion —

**Checklist**

- ☒ MU Objectives
- ☒ MU PH Measures
- ☒ MU CQM Measures

**Check**  
When each component of meaningful use reporting is complete, the system will check the corresponding checkbox.  
Click on the Save button to save the data.

### **Step 1: Enter Meaningful Use Reporting Period**

Select a reporting period that encompasses any continuous 90-day reporting period within the calendar year 2017. Enter your begin date. Once you enter the begin date, the system will automatically end date your Meaningful Use period. Information on the Meaningful Use reporting periods is available in the Frequently Asked Questions section of this document.

### **Step 2: Enter Meaningful Use CQM Reporting Period**

Select a reporting period that encompasses any continuous 90-day or greater reporting period within the calendar year 2017. In 2017, or your first year of attesting to Meaningful Use, you may select a 90-day or greater reporting period in the current calendar year for CQMs that differs from your reporting period for Meaningful Use.

### **Step 3: Save**

Please save your information by clicking the save button at the bottom left of the screen.

If you would like to fill out your Meaningful Use Information online, select the third tab at the top of this page, “MU-Objectives”.

## Meaningful Use Objectives

The page in Figure 17 below shows an example of the Meaningful Use Objectives required by CMS for eligible providers. Depending on what Stage of Meaningful Use you are in, you may see different Objectives. Eligible providers must meet or claim a valid exclusion for all objectives listed in the Meaningful Use set. On the right-hand side of this page, the system summarizes your status meeting the requirements. For example, this particular provider has filled out Meaningful Use information for 9 out of the required 9 Meaningful Use objectives.

To see the details on any objective, just move your cursor over the objective and click. See Figure 18 for details.

**Figure 17: Eligible Provider Meaningful Use Objectives Set Screen**

The screenshot displays a web application interface for 'Meaningful Use Objectives'. At the top, there is a blue header bar with a close button (X). Below the header is a navigation menu with tabs: 'MU-Overview', 'Summary', 'MU-Objectives' (highlighted with a red box), 'MU-Public Health', and 'MU-Clinical Quality Measures Set'. The main content area is titled 'Meaningful Use Objectives - EPs must fill out all 9 Meaningful Use Objectives.' and includes a legend: a red exclamation mark icon for 'Objective Not Completed Yet' and a green checkmark icon for 'Objective Completed'. A list of 9 objectives is shown, each with a right-pointing arrow icon and a status icon on the right. A red box highlights 'Objective 3: Computerized Provider Order Entry'. All 9 objectives have a green checkmark status icon.

Objective	Status
Objective 1: Protect Patient Health Information	Completed
Objective 2: Clinical Decision Support	Completed
Objective 3: Computerized Provider Order Entry	Completed
Objective 4: Electronic Prescribing	Completed
Objective 5: Health Information Exchange	Completed
Objective 6: Patient-Specific Education	Completed
Objective 7: Medication Reconciliation	Completed
Objective 8: Patient Electronic Access (VDT)	Completed
Objective 9: Secure Electronic Messaging	Completed

**Note:** The system accepts any mathematically valid entry. A completed objective, as signified by the icon, does not necessarily mean that you have passed the measure. It means you have completed the objective by entering information.

**Note:** You can learn about the Centers for Medicare and Medicaid Services' (CMS) Final Rule that changes the Meaningful Use requirements for providers and hospitals in 2017 by reviewing Maryland Medicaid's newsletter, [E-Connect](#).

**Figure 18: Eligible Provider Meaningful Use Objective Selection**

Meaningful Use Objectives - EPs must fill out all 9 Meaningful Use Objectives.

Objective Not Completed Yet Objective Completed

Objective 1: Protect Patient Health Information

Objective 2: Clinical Decision Support

Objective 3: Computerized Provider Order Entry

Objective

Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders into the medical record per state, local, and professional guidelines.

Measure 1

More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 2

More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 1 Exclusion

Exclusion Applies to you? ☒ Yes ☐ No

Exclusion Value: 10

Exclusion

Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

Measure 1 Compliance

Numerator 1:

Denominator 1:

Compliance

Numerator 1: The number of orders in the denominator recorded using CPOE.

Denominator 1: Number of medication orders created by the EP during the EHR reporting period.

Show All Descriptions

Figure 18 shows an example of the detail page for Objective 3: CPOE for Medication, Laboratory, and Radiology Orders. All of the objectives have similar pages. In this example, a provider may claim a valid exclusion or submit an appropriate numerator and denominator to meet the threshold for this objective. Information on the objective, how it is measured (i.e., what patients are counted to arrive at the percentage and what is the threshold percentage), and when a provider may claim exclusion for the objective, are listed on the left-hand side of the page. The appropriate information will be available for every objective.

On the right-hand side of the page, the system provides more detailed information about how to fill out the text boxes. If invalid information is entered, the system will return an error message with a description of the error. **The system does not validate whether the numbers entered meet the threshold value. They only ensure that the denominator is greater than or equal to the numerator.**

Providers can fill out all required information for the Objective at once, or they can save their progress and return at a later time.

**Note:** If at any time you change information on any objective, please save your information by clicking on the Save button at the bottom left-hand side of the screen.



## Meaningful Use Public Health Reporting

The requirements for meeting the Meaningful Use Public Health Objective are listed under the “MU-Public Health” tab. The consolidated public health objective has three measure options: Immunization Data Registries Submission, Syndromic Surveillance Reporting and Specialized Registry Reporting. The options for the Specialized Registry Reporting include Cancer, Prescription Drug Monitoring Program, or "case reporting" via Consolidated Clinical Document Architecture (CCDA). More information about these options can be obtained by emailing [mdh.mu\\_ph@maryland.gov](mailto:mdh.mu_ph@maryland.gov).

To increase the likelihood that providers submit data to the State's public health registries, Maryland has modified the public health requirement by establishing an order or precedence for public health reporting. If providers engage with Maryland Medicaid and the State's Health Information Exchange ("HIE"), CRISP, to submit cases to public health via CCDA, Maryland will count this action towards meeting "active engagement".

Examples of the public health reporting measures you will see are available in Figure 19. In Modified Stage 2, EPs will need to meet at least two measures to be compliant. On the right-hand side of this page, the system summarizes your status with meeting the reporting options.

To see the details on any measure option, just move your cursor over the measure and click. Each Public Health Measure's page is similar to each Meaningful Use Objective's page. See page 24 for an example of a Meaningful Use Objective page.

**Figure 19: Eligible Provider Meaningful Use Public Health Objective**

MU-Overview	Summary	MU-Objectives	MU-Public Health	MU-Clinical Quality Measures Set						
<p>Meaningful Use Public Health Objective - Providers will need to report for each of the public health measures in an order of precedence. They will need to either attest to the measure, claim an exclusion, or claim an alternate exclusion for each measure before proceeding to the next. EPs will need to meet at least 2 measures to be compliant. EPs in Stage 2 2015 can claim alternate exclusions for Syndromic Surveillance or Specialized Registry reporting, or both. If the EP claims alternate exclusions for both Syndromic Surveillance and Specialized Registry reporting, they must either meet the Immunization Registry reporting measure or claim an exclusion.</p> <p>🚫 - Objective Not Completed Yet    ✅ - Objective Completed</p> <table><tbody><tr><td>▶ Measure 1: Immunization Registries Data Submission</td><td>✅</td></tr><tr><td>▶ Measure 2: Syndromic Surveillance Reporting</td><td>✅</td></tr><tr><td>▶ Measure 3: Specialized Registry Reporting</td><td>✅</td></tr></tbody></table>					▶ Measure 1: Immunization Registries Data Submission	✅	▶ Measure 2: Syndromic Surveillance Reporting	✅	▶ Measure 3: Specialized Registry Reporting	✅
▶ Measure 1: Immunization Registries Data Submission	✅									
▶ Measure 2: Syndromic Surveillance Reporting	✅									
▶ Measure 3: Specialized Registry Reporting	✅									

**Note:** If at any time you change information on any objective, please save your information by clicking on the Save button at the bottom left-hand side of the screen.

## Meaningful Use Clinical Quality Measures Set

Requirements for meeting the Meaningful Use Clinical Quality Measures Set are listed under the Meaningful Use tabs. On the right-hand side of this page, the system summarizes your status meeting the requirements.

Providers must report any six CQMs relevant to their scope of practice, regardless of whether they report by attestation or electronically and regardless of participation year. Use your most recent version of CQMs from your EHR to attest. The version from your EHR may differ from the version in eMIPP, which is for the 2017 reporting period from the CMS eCQM Library. To see the details on any domain or measures, just move your cursor over the domain or measure, and click. Each Clinical Quality Measure is similar to the others. Detailed instructions appear when you select any one of the Clinical Quality Measures.

**Figure 20: Eligible Provider Meaningful Use Clinical Quality Measures Screen**

MU-Overview Summary MU-Objectives MU-Public Health **MU-Clinical Quality Measures Set**

Meaningful Use Clinical Quality Measures - Providers must respond to 9 measures across 3 domains. Use your most recent version of CQMs from your EHR to attest. ?

🔴 - Objective Not Completed Yet 🟢 - Objective Completed

▼ Domain 1 - Patient and Family Engagement

These are CQMs that reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient reported data and the ability to impact care at the individual patient level as well as the population level through greater involvement of patients and families in decision making, self care, activation, and understanding of their health condition and its effective management.

▶ CMS56: Functional Status Assessment for Hip Replacement	🟢
▶ CMS66: Functional Status Assessment for Knee Replacement	🟢
▶ CMS90: Functional Status Assessment for Complex Chronic Conditions	🟢
▶ CMS157 / NQF0384: Oncology: Medical and Radiation - Pain Intensity Quantified	🔴

▶ Domain 2 - Patient Safety

▶ Domain 3 - Care Coordination


▶ Domain 4 - Population and Public Health

▶ Domain 5 - Efficient Use of Healthcare Resources

▶ Domain 6 - Clinical Process/Effectiveness

**Note:** If at any time you change information on any objective, please save your information by clicking on the Save button at the bottom left-hand side of the screen.

## Upload Supporting Documentation

eMIPP allows providers to upload supporting documentation. Once you have selected the “Upload Document” tab, you can move your cursor to the upload icon  to upload information concerning your attestation.

Because every provider could be potentially selected for a post-payment audit, providers should have auditable proof that they meet patient volume qualifications. Medicaid recommends that you have an electronic, searchable file, such as Excel, that provides the following information:

- Provider name or identification number;
- Recipient name or identification number;
- Date of service;
- Payment status (paid or not paid); and
- Payor type (Medicaid, private, etc.)
- Payor Name (Medicaid, Medicare, UnitedHealth Care, etc)

To reduce the need for any post-payment audit, Medicaid recommends that you submit this information (or some auditable record proving that you meet patient volume requirements) at this stage in your registration.

As part of the pre-payment audit process, Medicaid requires that providers upload:

- An EHR-system generated report showing your objects and measures;
- A copy of the Security Risk Assessment;
- Screen shots for "yes/no" measures; and
- Supporting documentation for exclusions.


**Figure 21: Upload Supporting Documentation Screen**

FEDERAL INFORMATION	ELIGIBILITY	MEANINGFUL USE	UPLOAD DOCUMENT	Payment Year	Program Year	Payee NPI	View	Upload
				4	2015	1111111111		
				3	2014	1111111111		
				2	2013	1111111111		
				1	2011	1111111111		






When you select the upload icon, you will see the following pop-up screen. The eMIPP system will allow you to upload text files, word documents, Excel spreadsheets, and PDFs, among others. Simply click the “Choose File” button to select your file. Before uploading the document, you will need to provide a description of the file. Please be as specific as possible.

You can upload as many documents as you would like. Once a document is uploaded, it cannot be deleted.

**Figure 22: Selecting Supporting Documentation to Upload**

After uploading your document, you can click the view icon  to see a list of all the documents you have uploaded. From the document list, you can view your comments or download the files you have uploaded.

**Figure 23: View Uploaded Supporting Documentation**

FEDERAL INFORMATION	ELIGIBILITY	MEANINGFUL USE	UPLOAD DOCUMENT	Payment Year	Program Year	Payee NPI	View	Upload
				4	2015	1111111111		
				3	2014	1111111111		
				2	2013	1111111111		
				1	2011	1111111111		

## Submit to State

1. Read the terms and conditions, then do the following:

1. Select the printer icon to print the agreement if needed.
2. Click the checkbox to agree.
3. Click **Register** to submit the application. A pop-up box will ask for verification to submit the application.
4. Click **OK** to submit or **Cancel** to return to the application and make changes.

**Note:** After submitting the application, you cannot make changes. However, if your attestation is rejected by the State, you may make the necessary changes and reapply. If you have attested in error, please contact Maryland Medicaid at [mdh.marylandEHR@maryland.gov](mailto:mdh.marylandEHR@maryland.gov)

Figure 24: Eligible Provider Submit Attestation to State Screen

The screenshot displays the 'Eligible Provider Submit Attestation to State Screen'. At the top, there are three panels: 'Success' (with a green checkmark and text: 'We have received your registration information from the NLR. Please continue with state registration by completing tabs 1 through 3.'), 'Search Criteria' (showing 'Registration ID: 5500000004', 'NPI:', and 'Tax ID:'), and 'Login Information' (showing 'User ID:' and 'Profile: Provider Domain Admin'). Below these is a navigation bar with 'FEDERAL INFORMATION', 'ELIGIBILITY', and 'ATTESTATION' tabs. The 'ATTESTATION' tab is active, showing a 'NOTICE' and a 'Signature' section. The 'Signature' section contains a text area with a certification statement and a 'Register' button. A 'Windows Internet Explorer' pop-up window is overlaid on the screen, asking 'Do you want to submit your EHR Registration for State Review?' with 'OK' and 'Cancel' buttons. Four numbered callouts are present: '1. Print' points to a printer icon; '2. Accept' points to a checkbox labeled 'I accept the terms and conditions'; '3. Register' points to the 'Register' button; and '4. Submit' points to the 'OK' button in the pop-up window.

2. Validate that the payment information you chose during attestation is correct. Be sure to check that you have entered the correct Tax ID before submitting payment information and to double-check after submission.

**Figure 25: Attestation Complete Confirmation Screen**



The screenshot displays the 'Attestation Complete Confirmation Screen'. At the top, there are two main navigation buttons: 'MIPP Registration' and 'View Status of MIPP registration'. The 'MIPP Registration' button features a blue circular icon with a white plus sign and the text 'Start Medicaid Incentive Payment (MIPP) Registration' above an orange 'Start' button. The 'View Status of MIPP registration' button features a green circular icon with a white plus sign and the text 'View status of Medicaid Incentive Payment Registration' above an orange 'Track' button. Below these, a section titled 'EHR Incentive Program Registration Confirmation' contains the text: 'Your Medicaid EHR Incentive Program registration is successfully submitted for State review. If the below information is incorrect please contact our office at dhmh.MarylandEHR@maryland.gov.' A red rectangular box highlights the registration details: 'Registration ID : 1000111111', 'Name : Doe, John', 'Payee NPI : 999999999', 'Payee Tax ID : 111111111', and 'Pay to Provider : My Practice – My Practice NPI'.

EHR Incentive Program Registration Confirmation	
Your Medicaid EHR Incentive Program registration is successfully submitted for State review.	
If the below information is incorrect please contact our office at dhmh.MarylandEHR@maryland.gov.	
Registration ID	: 1000111111
Name	: Doe, John
Payee NPI	: 999999999
Payee Tax ID	: 111111111
Pay to Provider	: My Practice – My Practice NPI

3. Click **Logout** to exit the application.

**NOTE:** Once you have submitted with the State, **DO NOT RETURN TO THE CMS WEBSITE UNLESS INSTRUCTED BY THE STATE.** Returning to this website may hinder Maryland’s ability to review your attestation. Once you have submitted with the State, you should only be interacting with the State’s system.

## Hospital Registration

Providers will receive their Registration ID in the CMS registration (Step 1(b) on page 5). You cannot sign in to the site without this number. Log in to the Maryland EHR Registration and Attestation System at <https://emipp.health.maryland.gov/>

1. Login with eMedicaid username and password and click Submit.
2. On the next screen, select Go.
3. Under MIPP Registration, select Start.
4. Enter your 10-digit CMS Registration ID; select Search.

**Figure 26: Hospital CMS Certification Number Submission Screen**



5. On the next screen, you will see a page with three tabs. By default, you will begin on Tab 1, FEDERAL INFORMATION. Review the information and select the icon for the year in which you are participating in the program.

**Figure 27: Hospital Federal Information Verification Screen**




Payment Year	Program Year	Payee NPI	Provider Type
 4	2014		EH - Medicaid
 1	2012		EH - Dually Eligible

On this tab, you need to review and confirm the information from the CMS Registration and Attestation System. If there are any issues with the information that need to be corrected, STOP and go back to the CMS website and correct the issue(s). Then wait at least one full business day and reenter the system. If the updated information is displayed, you can continue. If not, wait one more day and try again. If the new information is not displayed, call the EHR Incentive Program Information Center at (888) 734-6433, or TTY (888) 734-6563.



6. After reviewing the information on Tab 1, click on Tab 2, ELIGIBILITY.

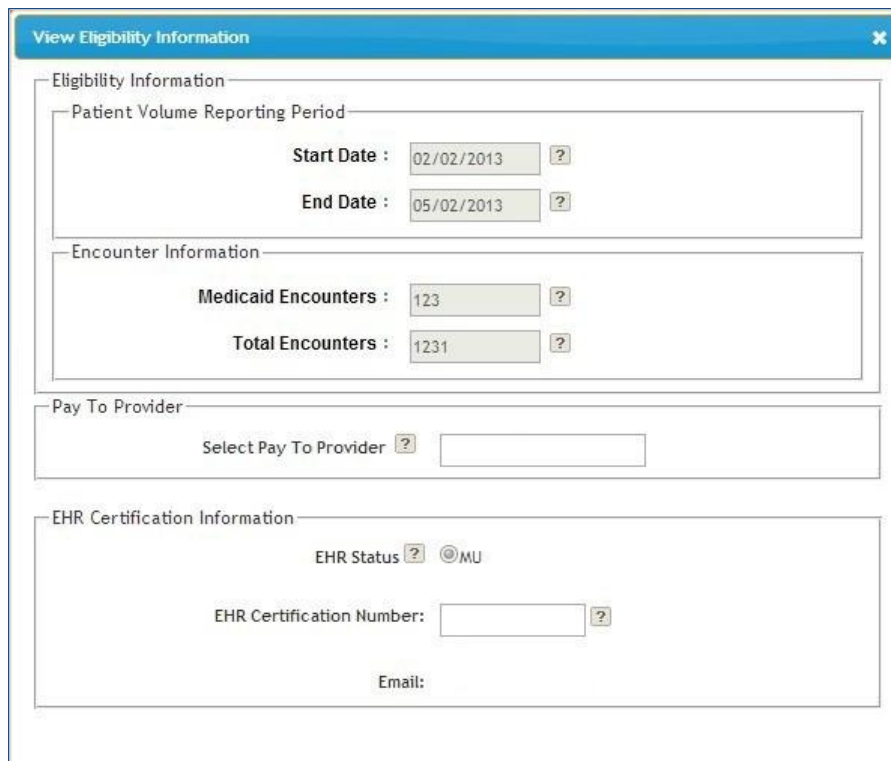
**Figure 28: Hospital Eligibility Determination Selection Screen**



Payment Year	Program Year	Certification Number	EHR Status
4	2014		Meaningful Use
2	2012		Meaningful Use
1	2011		Upgrade

7. Enter Eligibility Information.

**Figure 29a: Hospital Eligibility Determination Submission Screen**



**View Eligibility Information**

Eligibility Information

Patient Volume Reporting Period

Start Date : 02/02/2013 ?

End Date : 05/02/2013 ?

Encounter Information

Medicaid Encounters : 123 ?

Total Encounters : 1231 ?

Pay To Provider

Select Pay To Provider ?

EHR Certification Information

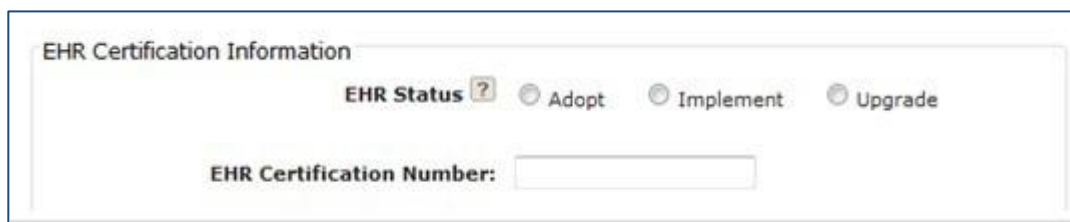
EHR Status ? ☒ MU

EHR Certification Number: ?

Email:



**Figure 29b: Hospital Eligibility Determination Submission Screen**



EHR Certification Information

EHR Status ? ☐ Adopt ☐ Implement ☐ Upgrade

EHR Certification Number:

**Reporting Period:** The default start date is today's date. Enter the start date (in MM/DD/YYYY format) that you want to start your eligibility reporting period. This is not your Meaningful Use reporting period in 2017; it is the continuous 90-day period in the prior federal fiscal year (between January 1, 2016 and December 31, 2016) that you are reporting your eligible/Medicaid patient volume. Once you fill in the start date, click in the end date field and the system will automatically fill in the end date. Note: Both the start and end date must be in the prior federal fiscal year—it cannot span multiple years. Your reporting period can be any consecutive 90-day period within the prior fiscal year. To ensure your hospital's eligibility, each hospital should contact MDH to obtain patient volume information before attesting. Hospitals can receive their patient volume information by emailing MDH at [mdh.MarylandEHR@maryland.gov](mailto:mdh.MarylandEHR@maryland.gov).

**EHR Status:** Select the appropriate EHR Status for your hospital. If you are a dually-eligible hospital and have already attested for the Medicare EHR Incentive Program, you will have the option to select “MU” (Meaningful Use). If you are participating in your second year with Medicaid or if you selected Meaningful Use in your first year, the only option you will have is to select “MU.”

**EHR Certification Number:** The CMS EHR Certification ID is made up of 15 alphanumeric, case sensitive characters and should be entered in ALL UPPER CASE.

8. Click Save.

**NOTE:** If you have already submitted Meaningful Use measures with Medicare, you will not have to re-submit your information with Maryland. Proceed to Step 10, below.

9. Submit Meaningful Use.

The process for submitting Meaningful Use information to the State is similar to the Eligible Provider submission process. Please go to page 21 to see this process.

10. Upload Supporting documentation.

All hospitals should upload their EHR product report showing their Menu Set and Core Set Meaningful Use information as well as their Clinical Quality Measures (CQMs). Medicaid will use this information to compare the hospital to the information they submitted with CMS or to validate Meaningful Use Submission for Medicaid-only hospitals.

See page 28 for details on uploading supporting documentation.

## 11. Attestation.

Read the terms and conditions, then do the following:

1. Select the printer icon to print the agreement, if needed.
2. Click the checkbox to agree.
3. Click Register to submit the application. A pop-up box will ask for verification to submit the application.
4. Click OK to submit or Cancel to return to the application and make changes.

**Note:** After submitting the application, you cannot make changes. However, if your attestation is rejected by the State, you may make the necessary changes and reapply. If you have attested in error, please contact Maryland Medicaid at [mdh.MarylandEHR@maryland.gov](mailto:mdh.MarylandEHR@maryland.gov).

**Figure 30: Hospital Attestation Submission Screen**

The screenshot displays the 'Hospital Attestation Submission Screen' with a sidebar on the left containing three tabs: 'FEDERAL INFORMATION', 'ELIGIBILITY', and 'ATTESTATION'. The 'ATTESTATION' tab is active. The main content area includes a 'Success' message with a green checkmark icon, stating: 'We have received your registration information from the NLR. Please continue with state registration by completing tabs 1 through 3.' Below this is a 'Search Criteria' section with fields for 'Registration ID: 5500000004', 'NPI: 1010000000', and 'Tax ID: 1010000000'. To the right is a 'Login Information' section with fields for 'U:' and 'Profile: Provider Domain Admin'. The main content area also features a 'Signature' section with a text area containing a legal disclaimer. A 'Windows Internet Explorer' pop-up window is overlaid on the screen, asking 'Do you want to submit your EHR Registration for State Review?' with 'OK' and 'Cancel' buttons. Red boxes and arrows highlight the following steps: 1. 'Print' (printer icon), 2. 'Accept' (checkbox labeled 'I accept the terms and conditions'), 3. 'Register' (orange 'Register' button), and 4. 'Submit' (a red box labeled '4. Submit' with an arrow pointing to the 'OK' button in the pop-up window).

## 12. Review confirmation.

After attesting with the State, please validate that the payment information you choose during attestation is correct.

**Figure 31: Hospital Attestation Complete Confirmation Screen**

**MIPP Registration**

Start Medicaid Incentive Payment (MIPP) Registration

**Start**

**View Status of MIPP registration**

View status of Medicaid Incentive Payment Registration

**Track**

**EHR Incentive Program Registration Confirmation**

Your Medicaid EHR Incentive Program registration is successfully submitted for State review.

If the below information is incorrect please contact our office at dhmh.MarylandEHR@maryland.gov.

Registration ID : 1000111111

Name : Doe, John

Payee NPI : 999999999

Payee Tax ID : 111111111

Pay to Provider : My Practice – My Practice NPI

13. Click Logout to exit the application.

**NOTE:** Once you have submitted with the State, **DO NOT RETURN TO THE CMS WEBSITE UNLESS INSTRUCTED BY THE STATE.** Returning to this website may hinder Maryland’s ability to review your attestation. Once you have submitted with the State, you should only be interacting with the State’s system.

## Track Registration Submission

1. Login with eMedicaid username and password and click Submit.
2. On the next screen, select Go.
3. Under MIPP Registration, select Track.
4. Enter your 10-digit NLR Registration ID; select Search
5. View the status of the submission. The green check marks indicate a completed step. The gears and green arrow indicate the current status.

**Figure 32: Track Application Status Bar**



Generally, submitted attestations will stay in the “State Review” status for an average of 45 days. During this time, the State is validating your information. If, after 45 days you have not received a follow up e-mail from the State, please contact us at [mdh.MarylandEHR@maryland.gov](mailto:mdh.MarylandEHR@maryland.gov).

Please include your Registration ID in either the subject line or body of your e-mail.

## Troubleshooting Issues

**Error:** Invalid Sign In

**Action:** You have not used the correct username and password. The username and password is the same as the eMedicaid login. If you have not registered at the eMedicaid portal, please do so first, then try logging in again.

**Error:** Error Communicating to the Web Service for Authentication.

**Action:** The application is having trouble communicating with the State Web service to authenticate your username and password. Wait and try again.

**Error:** Invalid Registration Details – The Maryland domain you are using does not match the CMS Registration ID.

**Action:** There is a mismatch between the NPI that you used to register in eMedicaid and the NPI that you used to register with CMS. Make necessary corrections and try again.

**Error:** Invalid Registration Details – CMS Registration ID not found. Please check your ID and enter again. If this issue persists upon re-entering, contact CMS to verify your Registration ID.

**Action:** You have not entered the correct registration ID, please check your welcome letter for the correct registration ID and try again.

**Error:** Invalid Registration Details – You are currently either not an active Maryland Medicaid Fee- For-Service (FFS) provider or you are not an eligible provider type for the EHR Incentive Program. You may not begin your Maryland EHR registration unless you meet both of these criteria. If you do not address the issue within 30 days, your Maryland EHR registration will be denied.

**Action:** Contact Provider Enrollment at (410) 767-5340.